

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03173

3197

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 72 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Charles</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Waldorf</b>		d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>none</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Rosanna Battles</b>		First	Middle	Last	4. DATE OF DEATH <b>March 2 1960</b>	Month	Day	Year 19		
5. SEX <b>F.</b>	6. COLOR OR RACE <b>C.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5 1867</b>	9. AGE (In years lost birthday) <b>92 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>George Alfred Battles</b>			14. MOTHER'S MAIDEN NAME <b>Adeline Hawkins</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>none Mrs. Jessie Jenkins, Indian Head, Md.</b>		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility - old age</b> INTERVAL BETWEEN ONSET AND DEATH <b>years</b> DUE TO <b>422.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Hypertension</b> years DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Aquasco</b>		(County) <b>Md.</b>	(State) <b>3/5/60</b>	
21. I certify that I attended the deceased from <b>Dec 31, 1959</b> , to <b>Mar 2, 1960</b> , that I last saw the deceased alive on <b>Mar 2, 1960</b> , and that death occurred at <b>10:15 AM</b> , from the causes and on the date stated above.										
ACTUAL SIGNATURE <b>Vahéh M. Seron M.D.</b>									ADDRESS (Street, city or town, state) <b>Aquasco Md</b>	DATE SIGNED <b>3/5/60</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-7-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Pauls Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home, Waldorf, Md.</b>			ADDRESS			24a. REC'D BY REGISTRAR DATE <b>MAR 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krause</b>		

STATE CHAIRMAN  
CREDIT CARD STATEMENT

ITEM	DESCRIPTION	AMOUNT	AMOUNT PAID	BALANCE DUE
1	ITEM 1	\$100.00	\$50.00	\$50.00
2	ITEM 2	\$200.00	\$100.00	\$100.00
3	ITEM 3	\$300.00	\$150.00	\$150.00
4	ITEM 4	\$400.00	\$200.00	\$200.00
5	ITEM 5	\$500.00	\$250.00	\$250.00
6	ITEM 6	\$600.00	\$300.00	\$300.00
7	ITEM 7	\$700.00	\$350.00	\$350.00
8	ITEM 8	\$800.00	\$400.00	\$400.00
9	ITEM 9	\$900.00	\$450.00	\$450.00
10	ITEM 10	\$1000.00	\$500.00	\$500.00
11	ITEM 11	\$1100.00	\$550.00	\$550.00
12	ITEM 12	\$1200.00	\$600.00	\$600.00
13	ITEM 13	\$1300.00	\$650.00	\$650.00
14	ITEM 14	\$1400.00	\$700.00	\$700.00
15	ITEM 15	\$1500.00	\$750.00	\$750.00
16	ITEM 16	\$1600.00	\$800.00	\$800.00
17	ITEM 17	\$1700.00	\$850.00	\$850.00
18	ITEM 18	\$1800.00	\$900.00	\$900.00
19	ITEM 19	\$1900.00	\$950.00	\$950.00
20	ITEM 20	\$2000.00	\$1000.00	\$1000.00
21	ITEM 21	\$2100.00	\$1050.00	\$1050.00
22	ITEM 22	\$2200.00	\$1100.00	\$1100.00
23	ITEM 23	\$2300.00	\$1150.00	\$1150.00
24	ITEM 24	\$2400.00	\$1200.00	\$1200.00
25	ITEM 25	\$2500.00	\$1250.00	\$1250.00
26	ITEM 26	\$2600.00	\$1300.00	\$1300.00
27	ITEM 27	\$2700.00	\$1350.00	\$1350.00
28	ITEM 28	\$2800.00	\$1400.00	\$1400.00
29	ITEM 29	\$2900.00	\$1450.00	\$1450.00
30	ITEM 30	\$3000.00	\$1500.00	\$1500.00
31	ITEM 31	\$3100.00	\$1550.00	\$1550.00
32	ITEM 32	\$3200.00	\$1600.00	\$1600.00
33	ITEM 33	\$3300.00	\$1650.00	\$1650.00
34	ITEM 34	\$3400.00	\$1700.00	\$1700.00
35	ITEM 35	\$3500.00	\$1750.00	\$1750.00
36	ITEM 36	\$3600.00	\$1800.00	\$1800.00
37	ITEM 37	\$3700.00	\$1850.00	\$1850.00
38	ITEM 38	\$3800.00	\$1900.00	\$1900.00
39	ITEM 39	\$3900.00	\$1950.00	\$1950.00
40	ITEM 40	\$4000.00	\$2000.00	\$2000.00
41	ITEM 41	\$4100.00	\$2050.00	\$2050.00
42	ITEM 42	\$4200.00	\$2100.00	\$2100.00
43	ITEM 43	\$4300.00	\$2150.00	\$2150.00
44	ITEM 44	\$4400.00	\$2200.00	\$2200.00
45	ITEM 45	\$4500.00	\$2250.00	\$2250.00
46	ITEM 46	\$4600.00	\$2300.00	\$2300.00
47	ITEM 47	\$4700.00	\$2350.00	\$2350.00
48	ITEM 48	\$4800.00	\$2400.00	\$2400.00
49	ITEM 49	\$4900.00	\$2450.00	\$2450.00
50	ITEM 50	\$5000.00	\$2500.00	\$2500.00
51	ITEM 51	\$5100.00	\$2550.00	\$2550.00
52	ITEM 52	\$5200.00	\$2600.00	\$2600.00
53	ITEM 53	\$5300.00	\$2650.00	\$2650.00
54	ITEM 54	\$5400.00	\$2700.00	\$2700.00
55	ITEM 55	\$5500.00	\$2750.00	\$2750.00
56	ITEM 56	\$5600.00	\$2800.00	\$2800.00
57	ITEM 57	\$5700.00	\$2850.00	\$2850.00
58	ITEM 58	\$5800.00	\$2900.00	\$2900.00
59	ITEM 59	\$5900.00	\$2950.00	\$2950.00
60	ITEM 60	\$6000.00	\$3000.00	\$3000.00
61	ITEM 61	\$6100.00	\$3050.00	\$3050.00
62	ITEM 62	\$6200.00	\$3100.00	\$3100.00
63	ITEM 63	\$6300.00	\$3150.00	\$3150.00
64	ITEM 64	\$6400.00	\$3200.00	\$3200.00
65	ITEM 65	\$6500.00	\$3250.00	\$3250.00
66	ITEM 66	\$6600.00	\$3300.00	\$3300.00
67	ITEM 67	\$6700.00	\$3350.00	\$3350.00
68	ITEM 68	\$6800.00	\$3400.00	\$3400.00
69	ITEM 69	\$6900.00	\$3450.00	\$3450.00
70	ITEM 70	\$7000.00	\$3500.00	\$3500.00
71	ITEM 71	\$7100.00	\$3550.00	\$3550.00
72	ITEM 72	\$7200.00	\$3600.00	\$3600.00
73	ITEM 73	\$7300.00	\$3650.00	\$3650.00
74	ITEM 74	\$7400.00	\$3700.00	\$3700.00
75	ITEM 75	\$7500.00	\$3750.00	\$3750.00
76	ITEM 76	\$7600.00	\$3800.00	\$3800.00
77	ITEM 77	\$7700.00	\$3850.00	\$3850.00
78	ITEM 78	\$7800.00	\$3900.00	\$3900.00
79	ITEM 79	\$7900.00	\$3950.00	\$3950.00
80	ITEM 80	\$8000.00	\$4000.00	\$4000.00
81	ITEM 81	\$8100.00	\$4050.00	\$4050.00
82	ITEM 82	\$8200.00	\$4100.00	\$4100.00
83	ITEM 83	\$8300.00	\$4150.00	\$4150.00
84	ITEM 84	\$8400.00	\$4200.00	\$4200.00
85	ITEM 85	\$8500.00	\$4250.00	\$4250.00
86	ITEM 86	\$8600.00	\$4300.00	\$4300.00
87	ITEM 87	\$8700.00	\$4350.00	\$4350.00
88	ITEM 88	\$8800.00	\$4400.00	\$4400.00
89	ITEM 89	\$8900.00	\$4450.00	\$4450.00
90	ITEM 90	\$9000.00	\$4500.00	\$4500.00
91	ITEM 91	\$9100.00	\$4550.00	\$4550.00
92	ITEM 92	\$9200.00	\$4600.00	\$4600.00
93	ITEM 93	\$9300.00	\$4650.00	\$4650.00
94	ITEM 94	\$9400.00	\$4700.00	\$4700.00
95	ITEM 95	\$9500.00	\$4750.00	\$4750.00
96	ITEM 96	\$9600.00	\$4800.00	\$4800.00
97	ITEM 97	\$9700.00	\$4850.00	\$4850.00
98	ITEM 98	\$9800.00	\$4900.00	\$4900.00
99	ITEM 99	\$9900.00	\$4950.00	\$4950.00
100	ITEM 100	\$10000.00	\$5000.00	\$5000.00

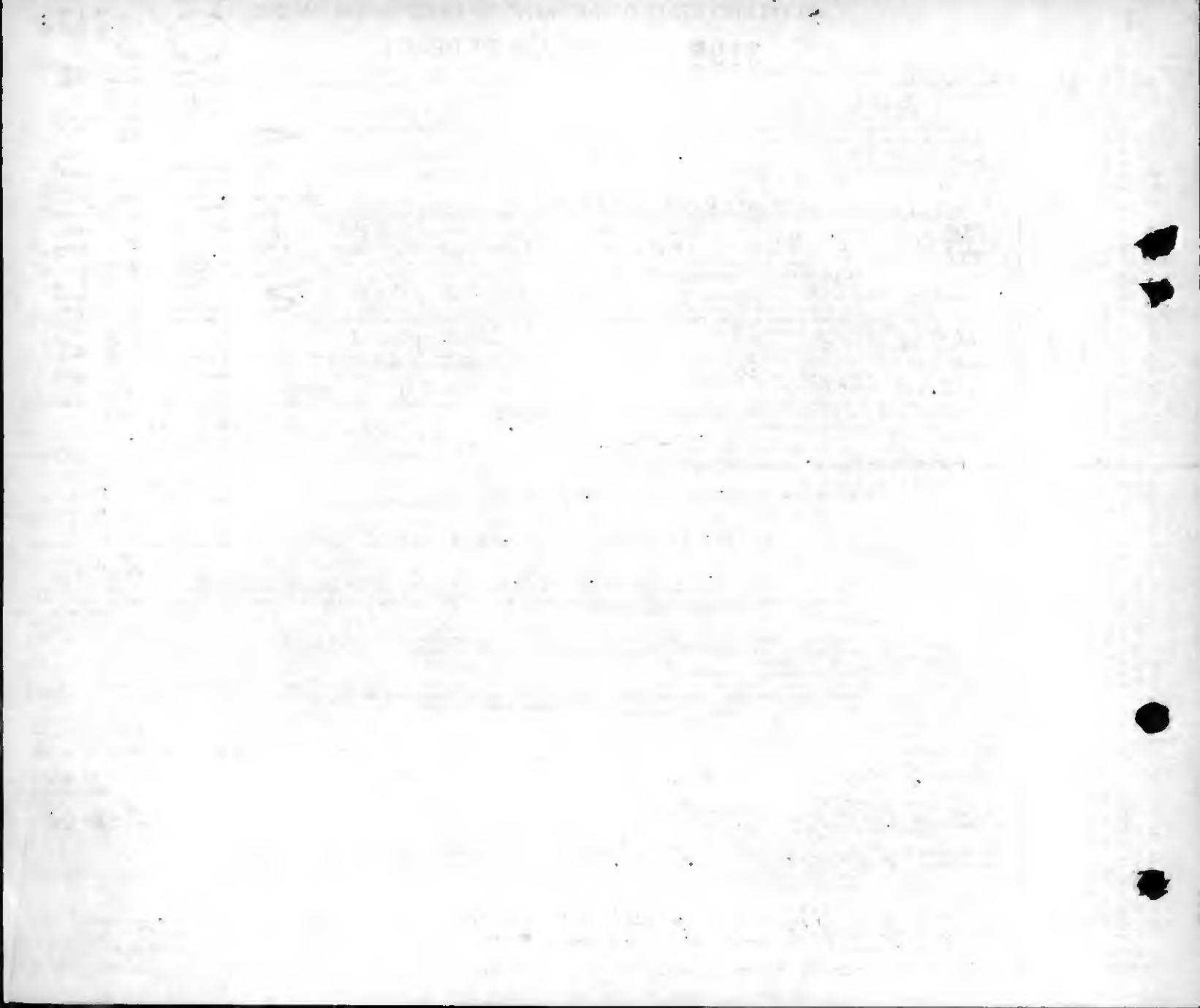
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03174

## 3198 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b 6 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Ruth Penn		First	Middle
		L	Penn
4. DATE OF DEATH March 8 1960		Month	Day Year
5. SEX Female		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10 Oct 1890		9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Westby Penn		14. MOTHER'S MAIDEN NAME Senny PENN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-36-3362	
17. INFORMANT LaRene P. Bowley		Address Faulkner	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO Respiratory collapse Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Hemorrhage of esophageal varan (c) DUE TO Cardio-vascular - hypertension disease		INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>8 Mar</u> , 19 <u>60</u> that I last saw the deceased alive on <u>8 March</u> , 19 <u>60</u> , and that death occurred at <u>11:54 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Arthur O. Wooldy</u> PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOOLDO</u>		ADDRESS (Street, city or town, state) <u>JARWOOD CLINIC</u> DATE SIGNED <u>8 Mar 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/1960	
22c. NAME OF CEMETERY OR CREMATORIAL Methodist Cemetery		22d. LOCATION (City, town, or county) Dentsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard Funeral Home, Inc.		24a. REC'D BY REGISTRAR DATE MAR 14 '60	
		24b. REGISTRAR'S SIGNATURE Cuthbert S. Kline	



03175

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**3199 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hughesville (Rural)</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hughesville (Rural)</b>		d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ALTON AUSTIN BRISCOE</b>		First <b>A</b>	Middle <b></b>	Last <b>Briscoe</b>	4. DATE OF DEATH <b>MARCH 20 1960</b>	Month <b>MARCH</b>	Day <b>20</b>	Year <b>1960</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 2, 1929</b>	9. AGE (in years last birthday) <b>30 yrs.</b>	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS. Days <b></b>	Hours <b></b>	Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOL BUS DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CHARLES CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>AUSTIN BRISCOE</b>				14. MOTHER'S MAIDEN NAME <b>LUCY SMITH</b>		Address <b>MR. AUSTIN BRISCOE - Hughesville MD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <b>NO. (Yes)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. AUSTIN BRISCOE - Hughesville MD</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTERNAL HEMORRHAGE</b> INTERVAL BETWEEN DUE TO 981X Conditions, if any, which gave rise to immediate cause (a), slating the underlying cause last. (b) <b>GUNSHOT WOUND of Abdical</b> 3-20-60									
DUE TO (b) <b>GUNSHOT WOUND of Abdical</b>									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Bryantown</b>	(County) <b>MD.</b>	(State) <b></b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>E. J. Edelen</b>		DATE SIGNED <b>3-20-60</b>							
EXAMINER'S NAME (Type) <b>E. J. EDelen M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-25-60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>St Marys</b>		22d. LOCATION (City, town, or county) <b>Bryantown, Md.</b>		(State) <b></b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The HUNTT Funeral Home, Waldorf, Md.</b>		ADDRESS <b></b>		24a. REC'D BY REGISTRAR DATE <b>MAR 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ANNUAL REPORT OF THE COMMISSIONER OF PIRATE  
AND OTHER OFFENDER CONTROL

REPORT FOR THE

YEAR ENDING

31 DECEMBER

2001

2002

2003

2004

2005

2006

2007

2008

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03176

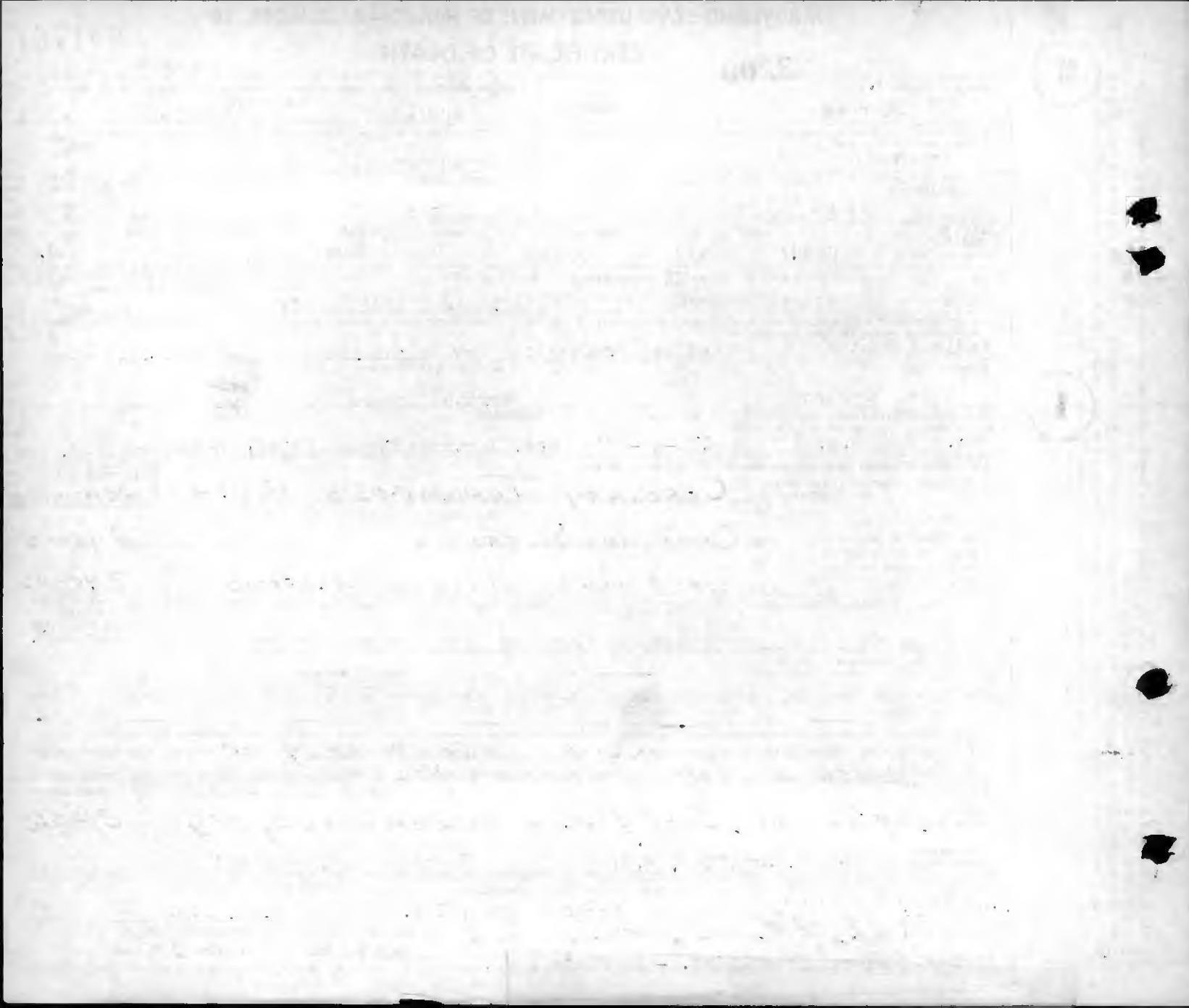
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryantown		c. LENGTH OF STAY IN 1b /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bryantown	
3. NAME OF DECEASED (Type or print) HARRY RAY COBURN		4. DATE OF DEATH Month March Day 19 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY Medical Profession	
11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Coburn		14. MOTHER'S MAIDEN NAME Harriett Coburn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes.		16. SOCIAL SECURITY NO. W.W. 1 030-24-2734	
17. INFORMANT Mrs. Gertrude Coburn (Wife) Bryantown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 20 minutes	
Coronary Thrombosis, Acute Coronary Sclerosis Generalized Arterio-Sclerosis		2 years 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that I attended the deceased from <u>Very</u> , 19 <u>56</u> , to <u>MARCH 19, 1960</u> that I last saw the deceased alive on <u>MARCH 2, 1960</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hughesville, Md.</u>			
ACTUAL SIGNATURE <u>John H. Griffin, M.D.</u>		DATE SIGNED <u>3/20/60</u>	
PHYSICIAN'S NAME (Type) John H. Griffin, M.D.		Hughesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/21/1960	
22c. NAME OF CEMETERY OR CREMATORIAL Lee Funeral Home, Inc.		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Arehart Funeral Home, Inc.		ADDRESS Arehart Funeral Home, Inc. - La Plata, Md.	
24a. REC'D BY REGISTRAR DATE MAR 30 '60		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.



03177

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

3201

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please excuse certificate, writing "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X La Plata</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John Spencer Dorsey</i>		4. DATE OF DEATH Last <i>2</i> , Month <i>2</i> , Day <i>22</i> , Year <i>1960</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>5-29-05</i>		9. AGE (In years last birthday) <i>54 yr.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State Road</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John F. Dorsey</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ophelia Bowman</i> Address <i>Evangeline Dorsey, La Plata, Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-16-4547</i>	
17. INFORMANT <i>Evangeline Dorsey</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Coronary Occlusion</i> DUE TO (c) <i>Coronary Heart Disease</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>3-22-60</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>La Plata</i> (County) <i>Md.</i> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>J. E. Deelen</i>		DATE SIGNED <i>3-22-60</i>	
EXAMINER'S NAME (Type) <i>J. E. Deelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-25-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Newtown M.E.</i>
22d. LOCATION (City, town, or county) <i>La Plata</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Huntt Funeral Home, Waldorf, Md.</i>		24a. RECEIVED BY REGISTRAR <i>MAR 28 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Clinton S. Kline</i>
ADDRESS		DATE	

WEDUCATIVE ENVIRONMENT & STUDY PLACE OF DEAFNESS

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03178

Reg. Dist. No.

3202

1. PLACE OF DEATH a. COUNTY	Charles	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE	Maryland	b. COUNTY	Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL)	Murphy	c. LENGTH OF STAY IN TB <small>(If a recent return)</small>	Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Pisgah	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

3. NAME OF DECEASED (Type or print)	Irving Alexander	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX	M	6. COLOR OR RACE	W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years (at birthday))	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Retired	10b. KIND OF BUSINESS OR INDUSTRY	U.S. Govt.	11. BIRTHPLACE (State or foreign country)	Maryland	12. CITIZEN OF WHAT COUNTRY?	U.S.A.	

13. FATHER'S NAME	Joseph S. Franklin	14. MOTHER'S MAIDEN NAME	Mary Milstead		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	No	16. SOCIAL SECURITY NO.	No	17. INFORMANT	Mervin A. Franklin, 54 Sergeant Ave. Somerville, Mass.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	977X	DUE TO	Knife wound of throat	3-24-60
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b),		DUE TO	Self inflicted	3-24-60
cause lost.		(c)		3-24-60

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted knife wound of throat		
20c. TIME OF INJURY Hour a. m. 3 p. m.	Month, Day, Year 3-24-60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
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ACTUAL SIGNATURE E.J. EDELEN	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 3-24-60
EXAMINER'S NAME (Type) E.J. EDELEN MD	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-29-60	22c. NAME OF CEMETERY OR CREMATORIAL Chicamuxen Methodist	22d. LOCATION (City, town, or county) Chicamuxen, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf, Md.	ADDRESS	24a. REC'D BY REGISTRAR MAR 30 '60	24b. REGISTRAR'S SIGNATURE Clyde S. Hunt

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSM(E)  
SM 9/55

W. H. Tamm  
University of California  
Berkeley, Calif.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03179

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <i>Charlottesville</i>		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) o STATE <i>VA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Melbury</i>	c. LENGTH OF STAY IN 1b <i>10 yrs</i>	b. COUNTY <i>Charlottesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Melbury</i>	
3. NAME OF DECEASED (Type or print) <i>Annie (NM N.) Griffith</i>		4. DATE OF DEATH <i>March 1 1960</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-4-74</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years from birthday) <i>85 yrs.</i>
11. BIRTHPLACE (State or foreign country) <i>The Plains, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William Griffith</i>		14. MOTHER'S MAIDEN NAME <i>Mary D. Ottstedt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Mary D. Ottstedt, Melbury, VA</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <i>Carcinoma Breast</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>5 Indian Head Ave</i>
21. I certify that I attended the deceased from <i>Sept 1959</i> to <i>March 1, 1960</i> , that I last saw the deceased alive on <i>Feb 27, 1960</i> , and that death occurred at <i>12:30 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <i>Frank A. Susan M.D. 5 Indian Head Ave 3-1-60</i>	
ACTUAL SIGNATURE <i>Frank A. Susan</i>		PHYSICIAN'S NAME (Type) <i>Frank A. Susan M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>3-3-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL HOME <i>Melbury Baptist Church</i>
22d. LOCATION (City, town, or county) <i>Melbury</i>		(State) <i>VA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard F. Fausch</i>		24a. REC'D. BY REGISTRAR DATE <i>MAR 14 '60</i>	24b. REGISTRAR'S SIGNATURE <i>James S. Moore</i>
irhart Funeral Home, Inc. - 14 Plaza, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03180

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	c. LENGTH OF STAY IN TB <i>Hrs.</i>	b. COUNTY <i>Charles</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newport</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial</i>	d. STREET ADDRESS <i>1</i>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ALVIN Maynard HICKS</i>	First <i>ALVIN</i>	Middle <i>Maynard</i>	Last <i>HICKS</i>
4. DATE OF DEATH <i>MARCH 29 1960</i>	Month <i>MARCH</i>	Day <i>29</i>	Year <i>1960</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 13 1959</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>James Scott</i>	14. MOTHER'S MAIDEN NAME <i>Geraldine Hicks</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	16. SOCIAL SECURITY NO. <i>None</i>	INFORMANT <i>Geraldine Hicks</i>	Address <i>Newport, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute infectious bronchitis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Spasmodic Laugutia</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No accident</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) <i>Spontaneous illness</i>	
20c. TIME OF INJURY Month Day Year Hour a.m. <i>no injury</i> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>La Plata, Charles, Md.</i> (County) (State)
21. I certify that I attended the deceased from <i>3-25-60</i> , 19, to <i>3-29-60</i> , 19, that I last saw the deceased alive on <i>3-28-60</i> , 19, and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>V.B. Dettor</i>	M.D.		ADDRESS (Street, city or town, state) <i>Box 387</i>
PHYSICIAN'S NAME (Type) <i>V. B. DETTOR, M.D.</i>	DATE SIGNED <i>3/29/60</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-31-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Trinity</i>	22d. LOCATION (City, town, or county) <i>Newport, Md.</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR <i>APR 4 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3205

## CERTIFICATE OF DEATH

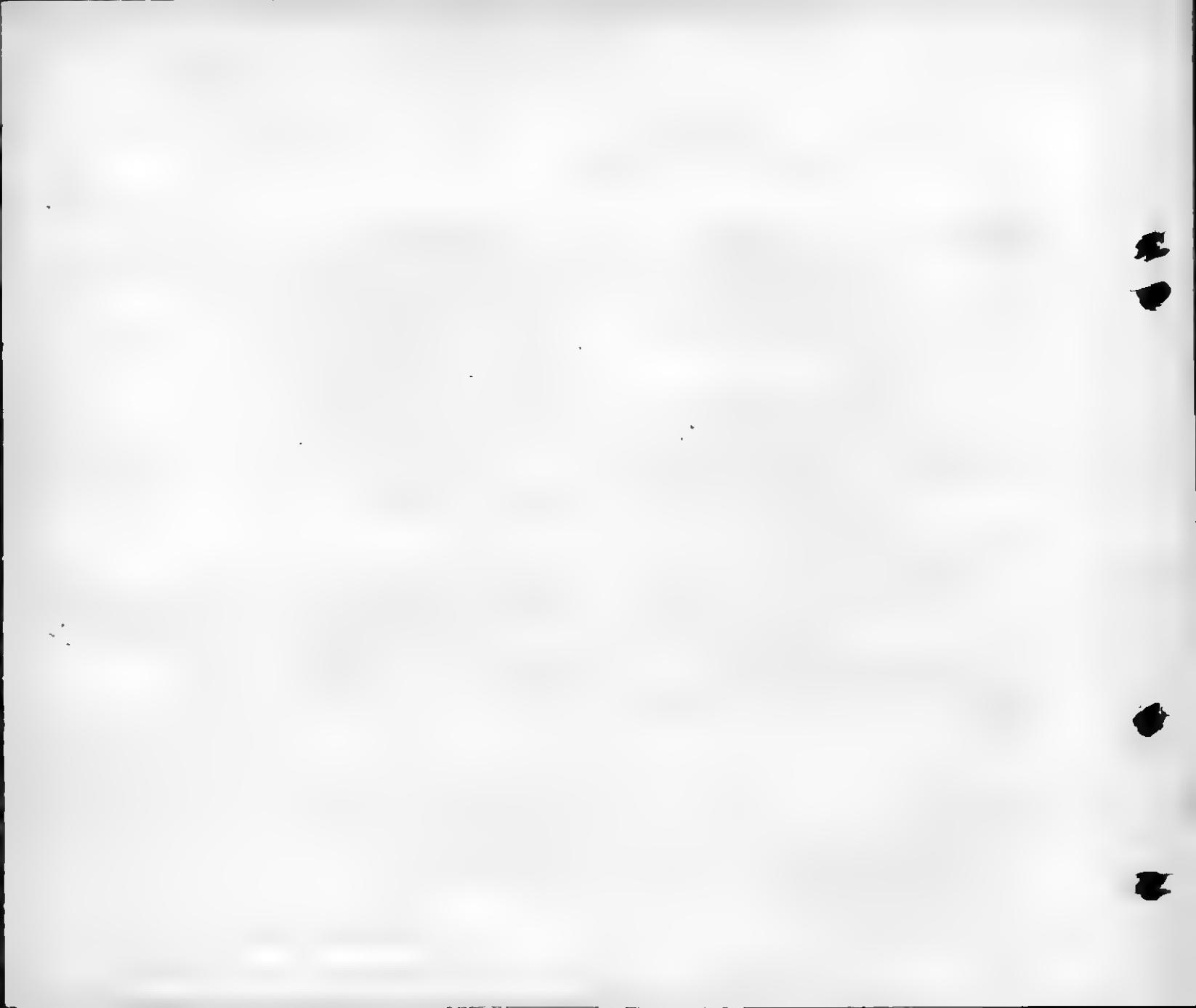
Reg. Dist. No.

03181

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryans Road</i>	c. LENGTH OF STAY IN 1b <i>20 yrs</i>	b. COUNTY <i>Charles</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryans Road</i>		d. STREET ADDRESS <i>1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Rachel</i>	Middle <i>Warren</i>	Last <i>Hurlburt</i>
4. DATE OF DEATH Month <i>March</i>	Day <i>16</i>	Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-9-89</i>
9. AGE (In years from birth) <i>70</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>John S. Warren</i>	14. MOTHER'S MAIDEN NAME <i>Fannie H. Compton</i>		15. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	17. SOCIAL SECURITY NO. <i>No</i>	18. INFORMANT <i>Mr. Lloyd Hurlburt Sr., Bryans Road, Md.</i>	19. ADDRESS <i></i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>4 + 3 X</i>			
(b) DUE TO <i>Hypertensive Heart Disease</i>			
(c) DUE TO <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10-61</i> , 19 <i>57</i> , to <i>3/16</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3/15</i> , 19 <i>60</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>5 Indian Head Ave</i>			
ACTUAL SIGNATURE <i>Frank A. Susan M.D.</i>	DATE SIGNED <i>3-16-60</i>		
PHYSICIAN'S NAME (Type)	<i>Frank A. Susan M.D. Indian Head, Md.</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-18-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Bumpy Oak</i>	22d. LOCATION (City, town, or county) (State) <i>Pomonkey, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>	24a. REC'D. REGISTRAR DATE <i>Arthur S. Hunt</i>	24b. REGISTRAR'S SIGNATURE DATE <i></i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 5 hours after death. Page 4

ATTENDED by the physician attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3200

## CERTIFICATE OF DEATH

03182

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE	
Charles MARYLAND		Md. Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville - Rural Life		c. LENGTH OF STAY IN 1b 16	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville - Rural	
3. NAME OF  (Type or print)		4. DATE OF DEATH Month Day Year	
First MARY Last K. JAMESON		March 26, 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> March 17, 1885	
9. AGE (In years last birthday) 75 yr.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Klinkiewicz		14. MOTHER'S MAIDEN NAME Fannie Wheatley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-34-8235	
17. INFORMANT Walter A. Jameson Sr., Hughesville Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. INTERVAL BETWEEN ONSET AND DEATH Coronary Thrombosis 4 hrs	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) } DUE TO } (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1960 to Mar. 26, 1960, that (I) (we) last saw the deceased alive on Mar. 26, 1960, and that death occurred at 6 A.M. from the causes and on the date stated above			
22a. SIGNATURE Roy Guyther		22b. DATE SIGNED 3-26-60	
22c. PHYSICIAN'S NAME (Type) Roy Guyther		22d. ADDRESS Mechanicsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-28-60	
23c. NAME OF CEMETERY OR CREMATORIAL St Mary's		23d. LOCATION (City, town, or county) Bryantown, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		25a. REC'D BY REGISTRAR DATE MAR 30 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Stine	

500

1  
FOR STATE  
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. 2 hours after death.

VS. A15ME  
5M 7/59

100-22

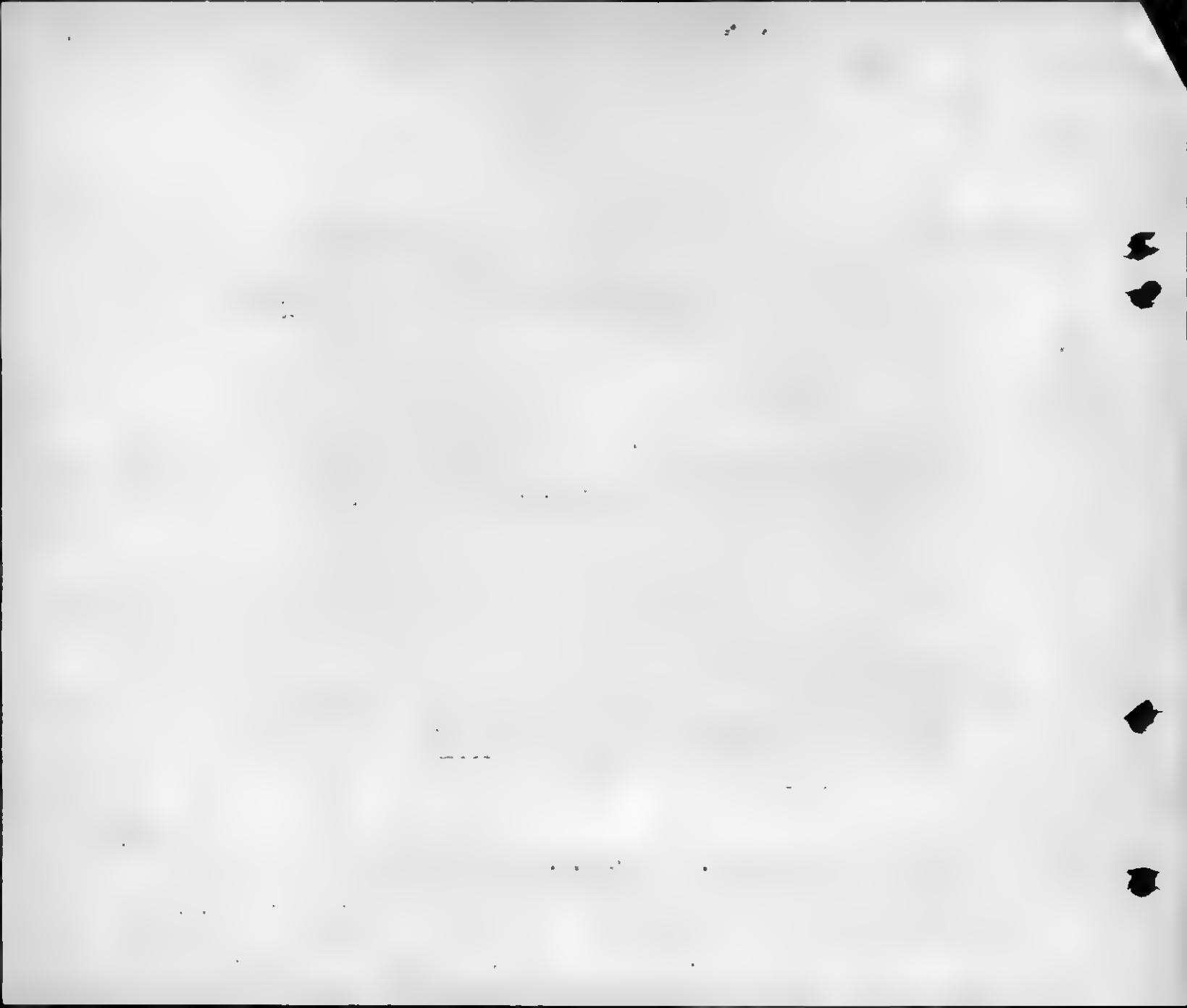
2 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 3207 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09185

1. PLACE OF DEATH a. COUNTY		Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		a. STATE Maryland		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate lim ls, write RURAL end give nearest town)		X Nanjemoy		(Rural)	
d. NAME OF HOSPITAL OR INST.TUTION (If not in hospital, g ve street address)		La Plata Hospital (Physicians Memorial)				H. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year		a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
LUDMILA ( N.M.N.)		MAKOWELSKI		March 23 19 60							
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF B.RTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		September 7, 1904 93 yrs.		Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. K ND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CIT.ZEN OF WHAT COUNTRY?					
Homme Wife		at Home		Poland		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Gustave Schwart		Maria Poch									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		None.		Nikolai Makowelski - Nanjemoy, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)		Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH					
43 d. /		DUE TO									
Conditions, if any, which gave rise to immediate cause		(b)									
(a), stating the underlying cause last.		DUE TO									
		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED?									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
19				Partial							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		<i>Russell S. Fisher</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type)		Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORI		22d. LOCATION (City, town, or country) (State)					
Burial		3/26/1960		Rock Creek Cemetery		Washington, D.C.					
23. FUNERAL DIRECTOR		ADDRESS		24e. REC'D BY REGISTRAR		24f. REGISTRAR'S SIGNATURE					
Arthur S. Thomas				MAR 30 '60							



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3208

Item 8 Film 6260 4-4-60 et

## CERTIFICATE OF DEATH

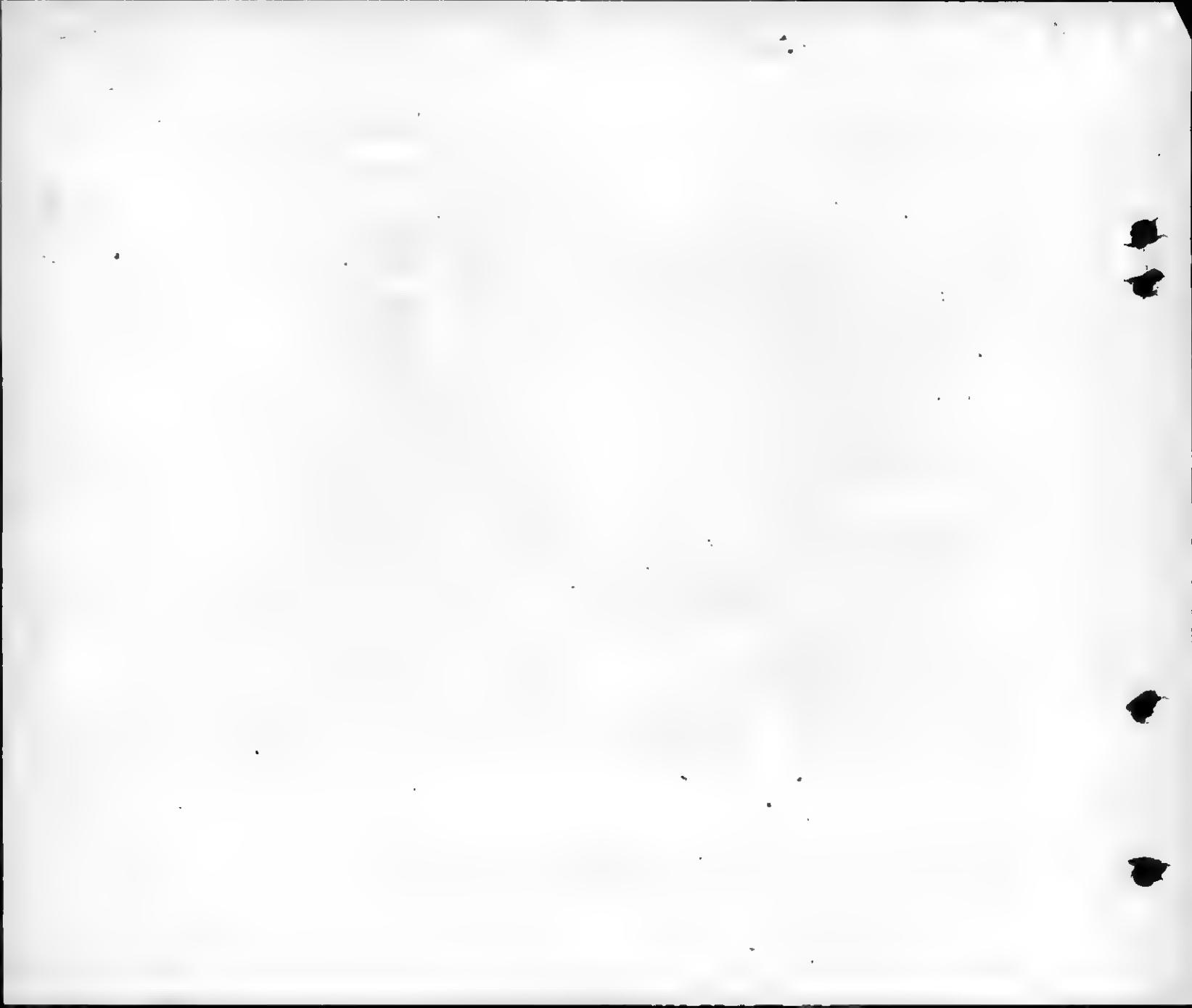
03184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Avenue		d. STREET ADDRESS St. Mary's Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) FRANK ALEXANDER		First	Middle	4. DATE OF DEATH MARTIN St.		Month 3	Day 24	Year 1960
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888 July 24, 1888	9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (State or foreign country) Charles Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Michael Martin		14. MOTHER'S MAIDEN NAME Heneritta Olivia						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-1478		INFORMANT Mrs. Ethel Bowling - La Plata, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  451X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) DUE TO (c)		Dissecting Aneurysm of Abdominal Aorta Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 3-24-60		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1958, 19, to 3-24, 1960, that I last saw the deceased alive on 3-24, 1960, and that death occurred at 60 M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE E.J. Edelen				M.D.		DATE SIGNED 3-24-60		
PHYSICIAN'S NAME (Type) E.J. EDelen								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/1960		22c. NAME OF CEMETERY OR CREMATORIUM St. Thomas Cemetery		22d. LOCATION (City, town, or county) Chapel Point, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Richard See		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 30 '60		24b. REGISTRAR'S SIGNATURE Cathleen S. Koenig		
AREHART FUNERAL HOME, INC. * La Plata, Md.								

**TO HONORABLE ATTENDING PHYSICIAN:** The law requires that the death certificate be executed by the physician attending the deceased. After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3209 CERTIFICATE OF DEATH**

03185

Reg. Dist. No.



12

FOR STATE  
HEALTH DEPT.

is necessary, please  
execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3210 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN lb 2 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) First Annie Middle M		Last Moran	
4. DATE OF DEATH Month March Day 13 Year 1960		5. SEX Female	
6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH May 7, 1877	
9. AGE (In years from birth to day) 82 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME John William Raley	
14. MOTHER'S MAIDEN NAME Elizabeth Therese Cecil		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 220-26-6334		17. INFORMANT Mrs. Paul Russell, Pecharysville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916. A DUE TO Burns, 2nd and 3rd degree, back, chest, trunk and thighs (1/2 of body surface)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cardiac decompensation, arterio-sclerotic heart disease		21. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) In air, 40 ft., 1000 ft. cloth caught in fire from burning wood above in no. 2, 1st floor by boiler out burns and occurred.	
20c. TIME OF INJURY Month, Day, Year Hour 7 p.m. 11:30 p.m. at work		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home		20f. (City or town) (County) (State) Hagerstown, Carroll, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John H. Griffin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Jo' H. Griffin, Acting		DATE SIGNED 3-14-60	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF 3-16-60	
22g. NAME OF CEMETERY OR CREMATORIAL ADDRESS Ft. Lincoln Cemetery		22h. LOCATION (City, town, or county) (State) 3201 Bladensburg Rd. Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf, Md.		24o. REC'D BY REGISTRAR DATE MAR 17 '60 24s. REGISTRAR'S SIGNATURE G. H. & K.	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3211

## CERTIFICATE OF DEATH

03187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE <b>Maryland</b>		b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b>		c. LENGTH OF STAY IN 1b <b>55-Hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Susie Inez Posey</b>		First	Middle	Last	4. DATE OF DEATH <b>3-3-60</b>	Month	Day	Year <b>19</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W-US</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-10-1885</b>	9. AGE (in years lost birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William Edward Morgan</b>		14. MOTHER'S MAIDEN NAME <b>Julia Towers</b>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Richard Polley-(Sonin Law) Indian Head Md</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>481X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30-Minutes</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Influenza-Viral</b> DUE TO						48-Hrs.			
(c) <b>Hypertension-Mild</b>						Indefinite			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDEPLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>None</b>							
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Indian Head Md</b>		(County)	(State)
21. I certify that I attended the deceased from <b>3-2-60</b> , 19, to <b>3-3-60</b> , 19, that I last saw the deceased alive on <b>3-3-60</b> , 19, and that death occurred at <b>12-45PM</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) <b>James E. Andrews</b>		ADDRESS (Street, city or town, state) <b>Indian Head Md</b>		DATE SIGNED			
22a. BURIAL/CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/7/1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Glenwood Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington, D.C.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arbhart Funeral Home, Inc. - La Plata, Md.</b>		ADDRESS <b>Arbhart Funeral Home, Inc. - La Plata, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 14 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03188

2212

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN lb <b>X</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Proctor</b>	Middle Last <b>March 23, 1960</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 23, 1960</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Ulysses Grant Bowman</b>		14. MOTHER'S MAIDEN NAME <b>Irene Elizabeth Proctor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>none</b>	INFORMANT <b>Irene E. Proctor, Doncaster, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Community - 6 M Bus Prey</b> DUE TO <b>76x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>45 min.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3-23-60</b> , 19, to <b>3-23-60</b> , 19, that I last saw the deceased alive on <b>3-23-60</b> , 19, and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>James E. Andrews, M.D. Indian Head, Md. 3-24-60</b>			
ACTUAL SIGNATURE <b>James E. Andrews, M.D.</b>		PHYSICIAN'S NAME (Type) <b>James E. Andrews, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/24/60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Iron Baptist Church</b>
22d. LOCATION (City, town, or county) <b>Hancock, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Augustus Keys</b>		24a. ADDRESS <b>Ironsides, Md.</b>	24b. REC'D. BY REGISTRAR DATE <b>MAR 28 '60</b>
		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3213

## CERTIFICATE OF DEATH

03183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Charles</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Plains</b>		c. LENGTH OF STAY IN 1b <b>White Plains</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Plains</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>Bernard</b>	Middle	Last <b>Shelton</b>	4. DATE OF DEATH <b>Mar 28 1960</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>June 10, 1886</b>	9. AGE (In years last birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homes</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James W. Shelton</b>		14. MOTHER'S MAIDEN NAME <b>Eliza</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Robert T. Shelton, Ma Plata, Md.</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO my card. Insuff.						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Ischaemic Cardi - val. Renal Disease						yes		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>3-10</b> , 19 <b>56</b> , to <b>3-28</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>3-25</b> , 19 <b>60</b> , and that death occurred at <b>10 A.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>G. R. G. Davis</b> M.D. ADDRESS (Street, city or town, state) <b>Brenton Ave.</b> DATE SIGNED <b>Aug 1961</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-30-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Homey Waldorf, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAR 31 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 72 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

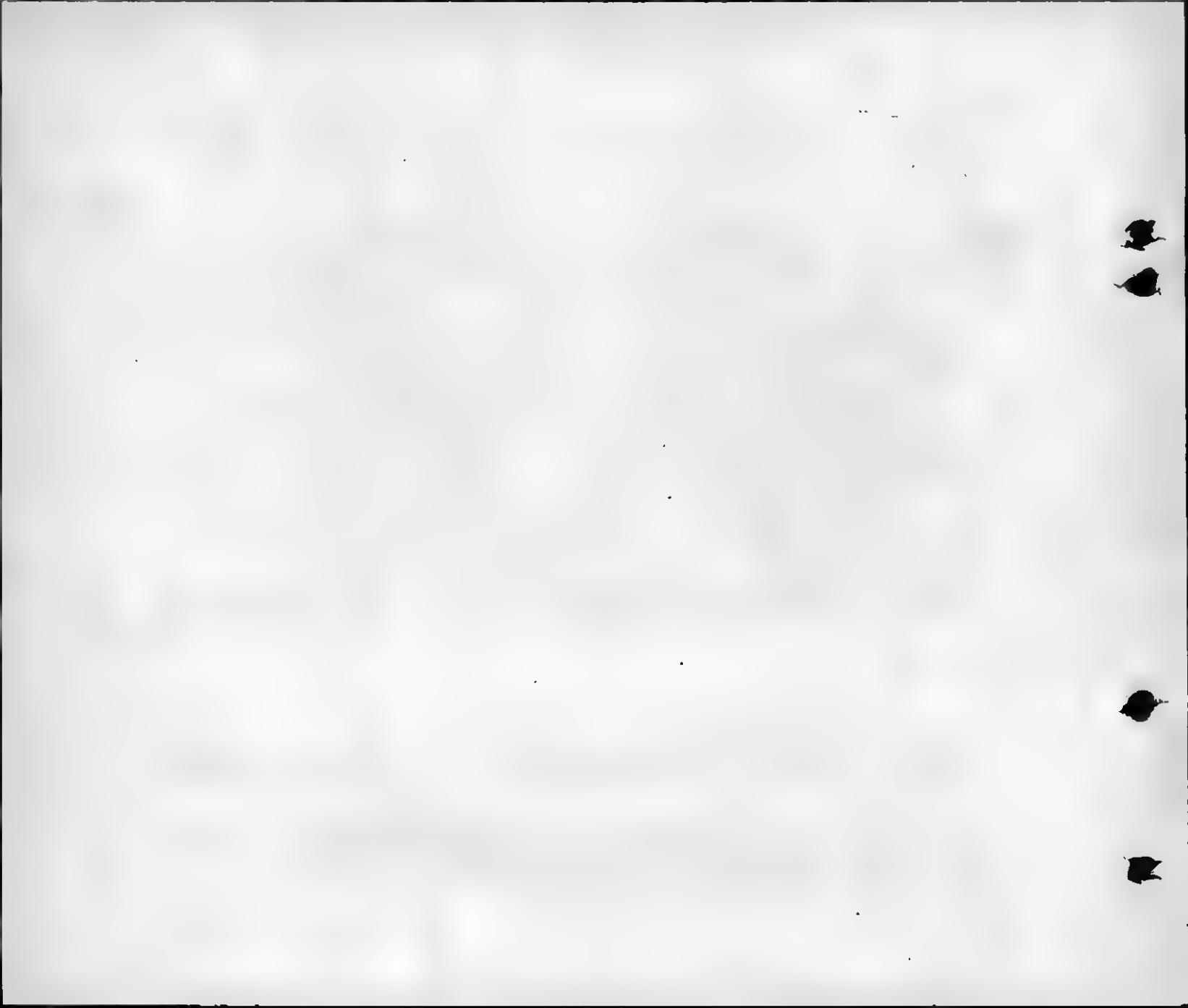
64450

Reg. Dist. No.

3214

**TO DEFEND MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES,	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville	c LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X HUGHESVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) WILLIE (Unknown) SWALES	First	Middle	Last
4. DATE OF DEATH	Month MARCH	Day 24	Year 1960
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (UNKNOWN) 1888	9. AGE (in years from birth to death) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) ST. MARY'S CO., MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME FRED SWALES		14. MOTHER'S MAIDEN NAME JULIA SCRIBNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT M. JAMES M. SWALES - INDIAN		Address (Unknown, Md.)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FREEZING 33IX DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? CEREBROVASCULAR ACCIDENT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died at home - spontaneous	
20c. TIME OF INJURY Month, Day, Year Hour 2a 20 p.m. 3-24 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Home 20f. (City or town) Hughesville (County) Charles (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>  ACTUAL SIGNATURE <u>V.B. Dettor</u> DATE SIGNED <u>3-28-60</u> EXAMINER'S NAME (Type) <u>V.B. DETTOR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/60	
22c. NAME OF CEMETERY OR CREMATORIAL - Mary's Cemetery		22d. LOCATION (City, town, or county) Bryans Town, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arebost Funeral Home, Inc.		ADDRESS Lab 224e. REGD. BY REGISTRAR APR 5 '60	
		24b. REGISTRAR'S SIGNATURE Collier & Hause	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3215 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

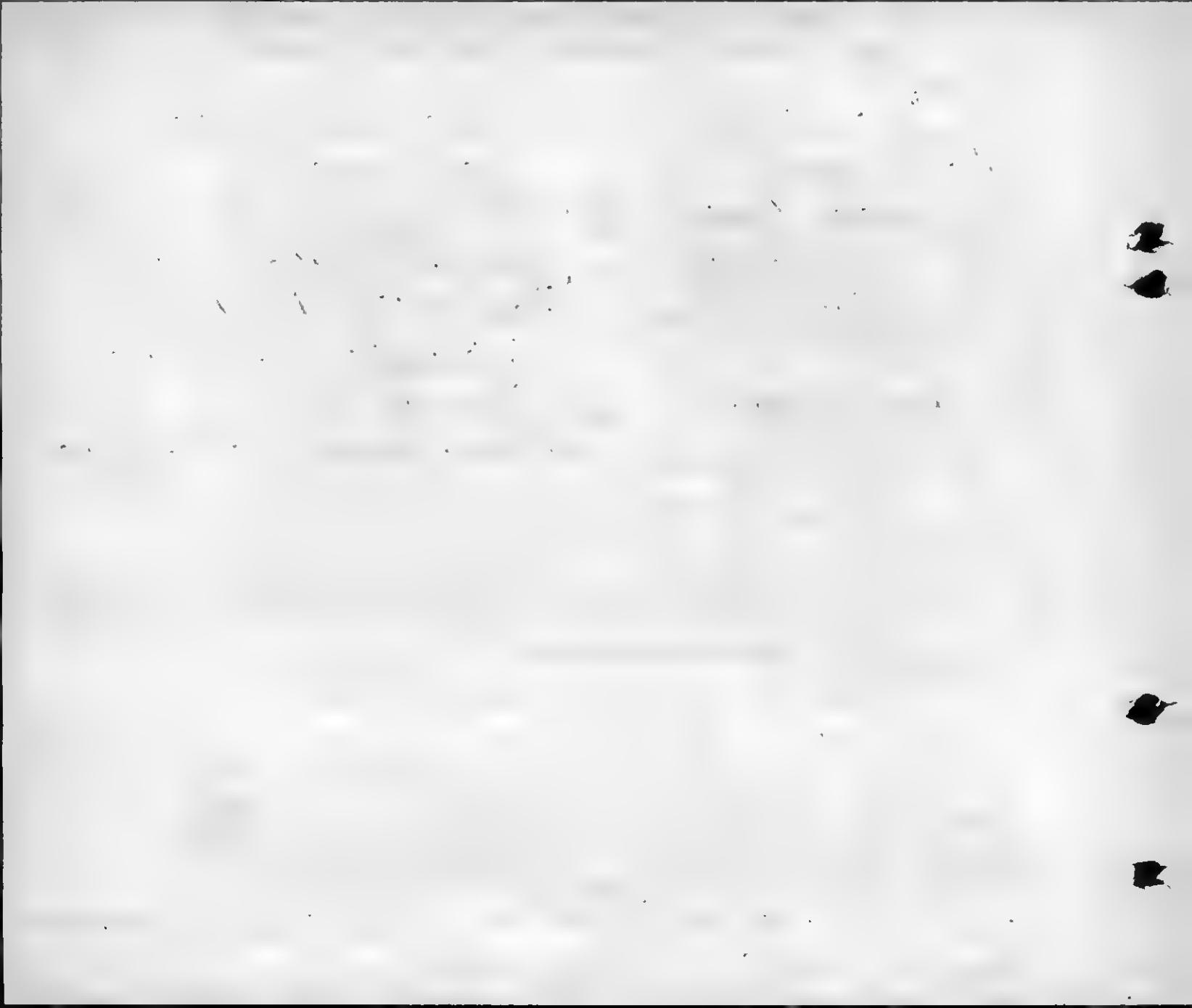
031960

Reg. Dist. No.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by the Director.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/transit, or removal.

1. PLACE OF DEATH a. COUNTY		Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		b. STATE Maryland		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		La Plata		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		La Plata		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Physician's Memorial Hosp.				e. IS RESIDENCE ON A FARM?					
f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Sharon				Swann	March	6	1960				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1YEAR	IF UNDER 24 HRS.				
F		Col.		Jan. 26 1959	yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
—		—		Washington, D.C.		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address							
Wilbert Swann		Emma		Wilbert Swann, La Plata, Md.							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
—		—		—		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and acute tonsillitis 480X DUE TO		4 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		(c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		Secondary to influenza							
20c. TIME OF INJURY Month, Day, Year Home 3-8-1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) Home		20f. (City or town) La Plata, Charles, Md.		(County) Charles		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE V. B. DETTOR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3-7-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 13-7-60		22c. NAME OF CEMETERY OR CREMATORIUM St. Ignatius		22d. LOCATION (City, town, or county) Bel Alton, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md.		ADDRESS		24a. REC'D BY REGISTRAR MAR 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hunt					
VS. AFMSE(5) SM 9/55											



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Form 60 4-4-60 et

Reg. Dist. No.

03191

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE			
<i>Charles</i> <i>Maryland</i>		<i>Maryland</i> <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY			
<i>Bell Elton</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
		<i>Bell Elton</i>			
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last		
<i>JAMES LESTER THOMAS</i>					
4. DATE OF DEATH	Month	Day	Year		
<i>3</i>		<i>19</i>	<i>1960</i>		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
<i>M</i>	<i>C</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>July 7 1935</i>	<i>24 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Former</i>		<i>Farming</i>		<i>McD.</i>	
12. CITIZEN OF WHAT COUNTRY?				<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
<i>James A Thomas</i>		<i>Mary F Harvey</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Name, no. or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
<i>UNKNOWN</i>		<i>Unknown</i>		<i>John J Thomas Caplan</i>	
18. CAUSE OF DEATH (Enter only one cause per line. (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		<i>Conflagration</i> <i>3-19-60</i>			
<i>116.0</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
(b)					
DUE TO					
(c)					
DUE TO		<i>House demolished by fire</i> <i>3-19-60</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
<i>3-19-60</i>				<i>Bell Elton, Charles</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>E.J. Edelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E.J. Edelen</i>		DATE SIGNED <i>3-19-60</i>			
22a. BURIAL/CREMATION. REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<i>Burial 3-21-60</i>		<i>3-20-60</i>		<i>Bell Elton McD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D. BY REGISTRAR DATE	
<i>Arthur J. Thomas</i>		<i>Arthur J. Thomas</i>		<i>Mar 30 '60</i>	
VS. A15ME(S) SM 9/55				24b. REGISTRAR'S SIGNATURE	



03192

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**3217 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Charles ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tompkinsville (Rural)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Tompkinsville (Rural)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <i>Pamela</i>		First A.	Middle Thomas	Last Thomas	4. DATE OF DEATH Month 3 - Day 24 Year 1960		
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 27, 1958	9. AGE (in years last birthday) 2 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Charles Co., Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Milton Thomas	14. MOTHER'S MAIDEN NAME Agnes V. Butler	Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Milton Thomas - Tompkinsville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Musles</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3-23-60
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
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ACTUAL SIGNATURE <i>E. J. Edelen</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>3-24-60</i>
EXAMINER'S NAME (Type) <i>E. J. Edelen</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-26-1960	22c. NAME OF CEMETERY OR CREMATORIUM Holy Grail Cemetery	22d. LOCATION (City, town, or county) Towson, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard J. Funeral Home Inc - La Plata, Md.</i>	ADDRESS Arrieta, La Plata, Md.	24a. REC'D BY REGISTRAR MAR 30 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Krause

TO DIRECT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any certificate, writing "Pending," in pencil in Item 18, Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3218

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03193

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>/</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First <i>JAMES</i>	Middle <i>EDWARD</i>	Last <i>TOYE</i>	4. DATE OF DEATH Month <i>MARCH</i> Day <i>26</i> Year <i>1960</i>
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5. SEX <i>MALE</i>	6 COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1912	9. AGE (In years last birthday) 48 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>Edward Toye</i>	14. MOTHER'S MAIDEN NAME <i>ALICE Love</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>244-14-2904</i>	17. INFORMANT Address <i>Mrs. Mary Ann Toye, Hughesville, Md.</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	<i>Shock and Hemorrhage.</i>	
<i>12X</i>	INTERVAL BETWEEN ONSET AND DEATH <i>1 min.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) <i>Cerebral Hemorrhage</i>	INTERVAL BETWEEN ONSET AND DEATH <i>1 min.</i>
	<i>and Bilateral Compound Fractures-Tibia</i>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>Multiple fractures left forearm</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Pedestrian - auto accident</i>

20c. TIME OF INJURY Month, Day, Year <i>3-26 1960</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>Highway</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Hughesville, Charles, Md.</i>	20f. (City or town) (County) (State)
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21. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .
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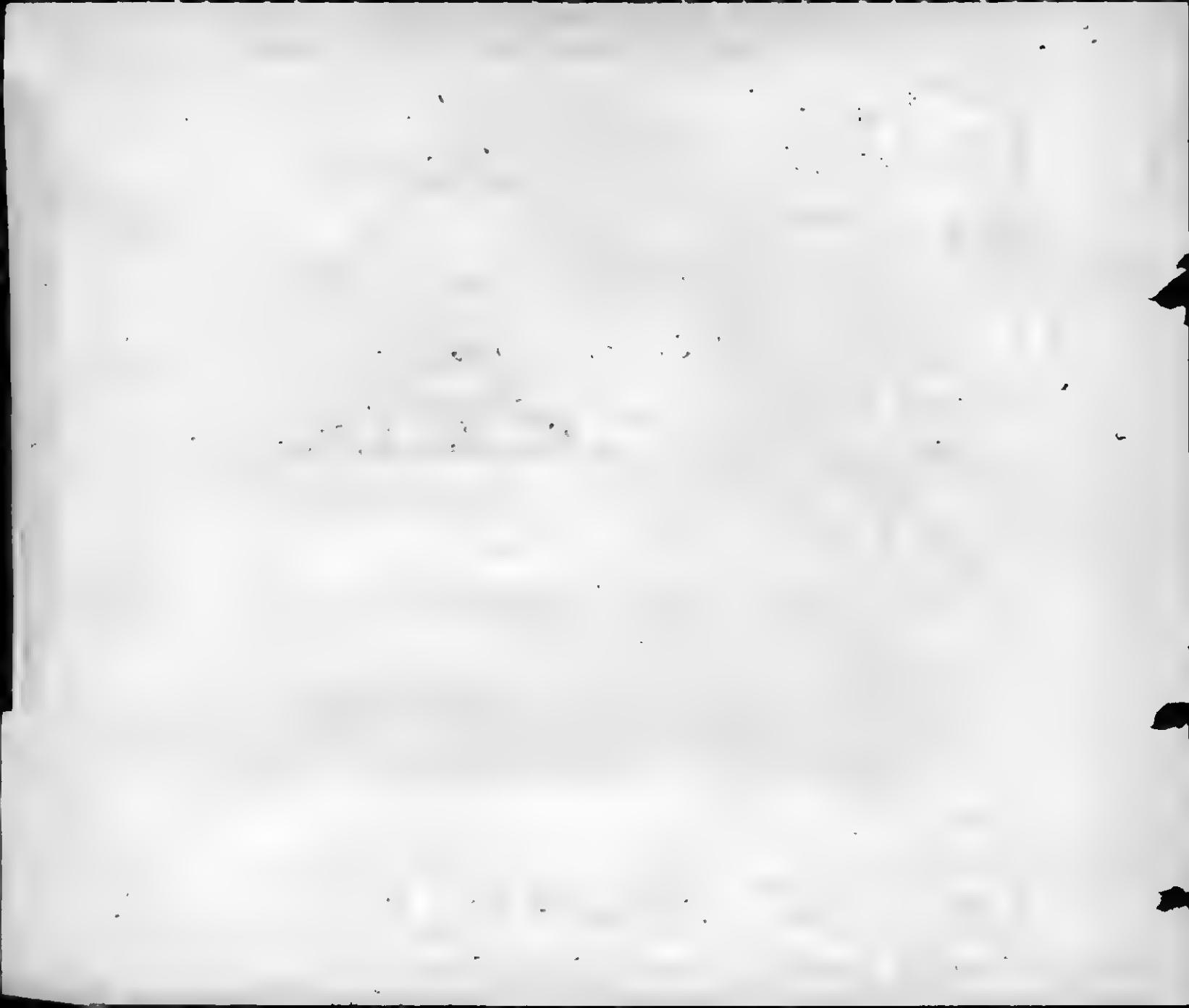
ACTUAL SIGNATURE <i>V.B. Dettor</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) <i>V.B. DETTOR</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>

22a. BURIAL, CREMATON, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-30-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>S.T. John's A.M.E.</i>	22d. LOCATION (City, town, or county) <i>Hughesville, Md.</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home, Waldorf, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>Mar 30 4 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Carla S. Tamm</i>
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TOP SECRET MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the register prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3219

## CERTIFICATE OF DEATH

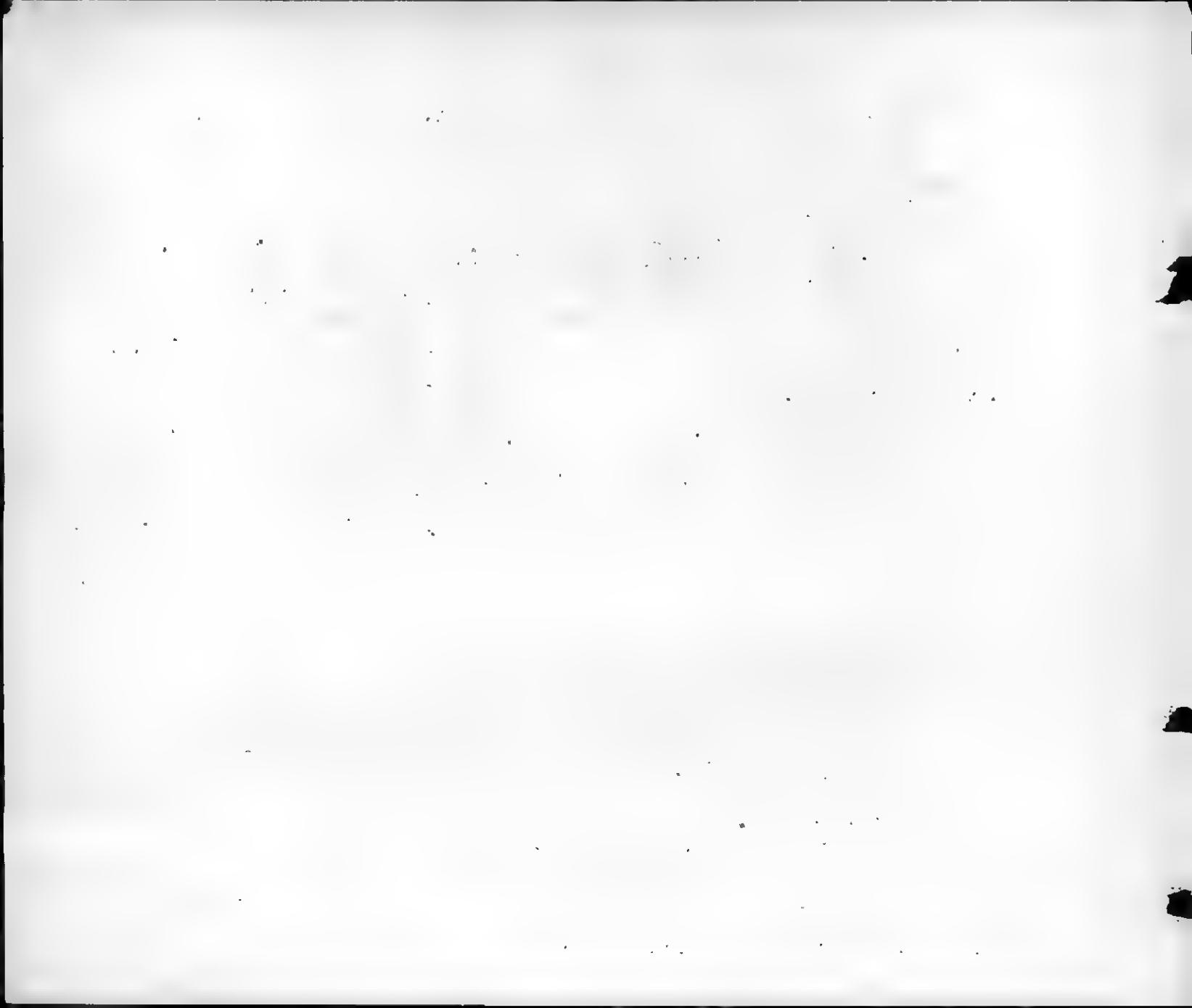
Reg. Dist. No.

03194

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>City -</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Waldorf</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) INSTITUTION <i>Marys New Hospital</i>		e. STREET ADDRESS <i>/</i>	
3. NAME OF DECEASED (Type or print) <i>MARY GERTRUDE</i>		First <i>MARY</i>	Middle <i>GERTRUDE</i>
		Last <i>Vernon</i>	4. DATE OF DEATH 3 Month 21 Day 1960 Year
5. SEX <i>F</i>		6. COLOR OR RACE <i>LL</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Dorsey Montgomery</i>	14. MOTHER'S MAIDEN NAME <i>Eliza Gates</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	INFORMANT <i>Mrs. Margaret Gardner, Waldorf, Maryland</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <i>334X</i>		Address <i>Cecilie Van Cittert &amp; Schaefer</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)  <i>Multiple exudate</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3-14 to 3-21-60</i>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-14</i> , 19 <i>60</i> , to <i>3-21</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3-20</i> , 19 <i>60</i> , and that death occurred at <i>547</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. J. E. P. L. / M.D.</i>		ADDRESS (Street, city or town, state) <i>Waldorf, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>E. J. E. P. L. / M.D.</i>		DATE SIGNED <i>3-21-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-24-60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>St Pauls</i>		22d. LOCATION (City, town, or county) <i>Waldorf, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Huntt Funeral Home, Waldorf, Maryland</i>		ADDRESS <i>The Huntt Funeral Home, Waldorf, Maryland</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 28 '60</i>
		24b. REGISTRAR'S SIGNATURE <i>Cathleen L. Knaus</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3220

## CERTIFICATE OF DEATH

174453

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pomfret</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pomfret</i>	
f. STREET ADDRESS <i></i>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARY</i>		First <i>Anne</i>	Middle <i>WILLET</i>
4. DATE OF DEATH <i>MARCH 31 1960</i>	Month <i>MARCH</i>	Day <i>31</i>	Year <i>1960</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 11 1877</i>
9. AGE (In years lost birthday) <i>82 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Anthony Winkler</i>	14. MOTHER'S MAIDEN NAME <i>Emily Adams</i>	15. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) <i>No</i>	17. SOCIAL SECURITY NO <i>NONE</i>	18. INFORMANT <i>Walter Willett, White Plains, Md.</i>	Address <i></i>
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>420.0</i> (b) <i>Atherosclerotic Heart Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Cerebrovascular Accident</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, note by medical examiner) <i>No accident</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>	
20c. TIME OF INJURY Hour <i>no injury</i>	Month <i>19</i>	20d. INJURY OCCURRED White of work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
20f. (City or town) <i>Waldorf</i>	(County) <i>Charles</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>2-7 1960</i> to <i>3-31 1960</i> that I last saw the deceased alive on <i>3-29 1960</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>V.B. Dettor</i>			
ADDRESS (Street, city or town, state) <i>Box 397 La Plata</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-4-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St Josephs</i>
22d. LOCATION (City, town, or county) <i>Pomfret, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR DATE APR 6 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3221

## CERTIFICATE OF DEATH

Reg. Dist. No.

03195

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Maryland</b>		3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaPlata Md.</b>		c. LENGTH OF STAY IN 1b <b>34-Days</b>		d. STREET ADDRESS <b>Rural Waldorf Md</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital, LaPlata Md</b>									
3. NAME OF DECEASED (Type or print) <b>Mildred Sara Willett</b>		Fist	Middle	Last	4. DATE OF DEATH <b>3-10-60</b>	Month	Day	Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>8-16-18</b>	V AGE (In years last birthday) <b>41</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife WORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>American-USA.</b>			
13. FATHER'S NAME <b>John Willett.</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Willett</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>John Willett, (Brother) Waldorf Md</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Cirrhosis</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Gastritis</b> DUE TO (c) <b>Chronic Ulcers of Duodenum</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Indefinite</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Patient had macked ascites which recurred immediately after tapping</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Patient had macked ascites which recurred immediately after tapping</b>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Indian Head Md</b>		20f. (City or town) (County) <b>Indian Head Md</b>		(State) <b>Md</b>	
21. I certify that I attended the deceased from <b>2-5-60</b> , 19, to <b>3-10-60</b> , 19, that I last saw the deceased alive on <b>3-10-60</b> , 19, and that death occurred at <b>7:45PM</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Indian Head Md</b>									
DATE SIGNED <b>3-12-60</b>									
ACTUAL SIGNATURE <b>James E. Andrews</b>		PHYSICIAN'S NAME (Type) <b>James E. Andrews MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-14-60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>OAKLAND Cem.</b>		22d. LOCATION (City, town, or county) <b>Waldorf, Md.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>		ADDRESS		24a. REC'D. BY REGISTRAR <b>MAR 17 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hunt</b>			
VS A1S (4) 15M 9/SS									

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3222

## CERTIFICATE OF DEATH

Reg. Dist. No. 03196

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE MD b. COUNTY CALVERT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA,	c. LENGTH OF STAY IN 1b 3 mos.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCE FREDERICK 04X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) INSTITUTION BOWLING'S HOTEL, Charles St.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bertha Ann YOUNG	First	Middle	Last
4. DATE OF DEATH March 15 1960	Month	Doy	Year
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 30, 1879
9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) BOWERS, Md		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Berri Stafford		14. MOTHER'S MAIDEN NAME Tda Cusick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No	
17. INFORMANT VIOLET YOUNG - PRINCE FREDERICK, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  443X		Respiratory collapse, CVA 2 hrs.	
Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause lost.		DUE TO hypertension, cardiovascular disease 20 yrs.	
(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 48IX INFLUENZA in January, never fully recovered			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 Jan, 1960, to 15 Mar, 1960, that I last saw the deceased alive on 15 March, 1960, and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) DATE SIGNED ARTHUR O. WOODY M.D. JARWOOD CLINIC 15 Mar 60 ARTHUR O. WOODY LAPLATA, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Mar. 17, 1960		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM Aubury Cemetery	
22d. LOCATION (City, town, or county) Berwyn, Calvert Co.-Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE A. A. Harkness & Son - Mortuaries, Md		24a. REC'D BY REGISTRAR DATE MAR 17 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 to be retained by the hospital or attending physician.

**BURIAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SI ECONOMIA - VAI ANO DIRETTORE DI SOGNO  
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